South Carolina Workers' Compensation Commission
1612 Marion Street • Post Office Box 1715
Columbia, South Carolina 29202-1715
(803) 737-5723
www.wcc.sc.gov

WCC File #: _____
Carrier File #: _____
Carrier Code #: _____
Employer FEIN #: _____

Claimant's Name: _____ Employer's Name: _____

Address: _____ Address: _____

City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip: _____

Home Phone: ( ) - Work Phone: ( ) - Carrier: _____

Preparer's Name: _____ Preparer's Phone #: ( ) -

This form is only applicable to injuries by accident occurring on or after July 1, 2007 pursuant to Title 42-15-60 (A) as amended. The execution of this document is an agreement between the parties relating to a Workers' Compensation claim under §§42-1-160, 42-1-172 or 42-11-10.

Date of Injury or Illness_____

The above parties agree to pay and accept compensation based on the following facts:
A compensable ☐ Injury ☐ Illness ☐ Repetitive Trauma occurred on: _____ (month/day/year).

The injury was to _____ body part(s) injured and also the injury affected _____ other body part(s).

The authorized treating physician has released the Claimant from his or her care and has found maximum medical improvement on _____ (month/day/year).
with an impairment rating of_____.

Average weekly wage _____ Compensation rate _____

By agreement of the parties, the following award has been referred to the Commission for approval:

____ Percentage loss of use to: _____ (body part(s) injured).	_____weeks
____ Percentage loss of use to:_____(body part(s) affected).	_____weeks
____ Percentage loss of use to: whole person	_____weeks
Disfigurement to: _____	_____weeks
Wage Loss: $_____amount	_____weeks
Total and Permanent Disability: _____	_____weeks
Other: _____	_____weeks

Estimated award (number of weeks times compensation rate) $ _____
The estimated award is subject to verification by the Commission

Additionally, the Employer's Representative agrees to pay and the Claimant accepts the following medical care and treatment as recommended by the authorized treating physician pursuant to the attached physician's statement, **Form 14B**

Additional medical ordered: _____ Yes _____ No
See attached 14B physician's statement dated: _____

This agreement is binding on approval by the Commission. A claim for additional compensation based on a worsening of the Claimant's condition **must be filed no later than one (1) year from the date of the last payment of compensation.** Only medical care specifically detailed herein will be paid under this agreement. If a dispute arises with regard to continued medical treatment, either party may request a hearing before the Commission pursuant to 42-15-60(B) 3 and (C).

Claimant's Signature	Date Agreement Signed	Attorney/Witness/Translator
Employer's Representative	Attorney for Carrier	Email
Deputy Commissioner	Date agreement approved	Jurisdictional Commissioner